CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION 00		NSTRUCTION 00	(X3) DATE SURVEY  COMPLETED			
		155249	A. BUII B. WIN	LDING			08/12/2	
)	AD OUTDED OF SUPEY		D. WIIN		ЕЕТ А	ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIER			6000	6 BF	RANDY CHASE COVE		
KINDREI	O TRANSITIONAL C	CARE AND REHAB-FORT WAYNE		FOF	RT V	VAYNE, IN46815		
(X4) ID		TATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	`	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
F0000	REGULATORT OR	ESC IDENTIF TING INFORMATION)		IAG	$\dashv$			DAIL
1 0000								
	This visit was for	the Investigation of	F0	0000	I			
	Complaint IN000	94324. This visit						
	resulted in a parti	-						
	survey-immediate	e jeopardy.						
	G 1: . BT000	004204 G 1 4 4 4 1						
	•	994324 - Substantiated.						
		ciencies related to the						
	anegations are cr	ted at F223, F225, F226.						
	Unrelated deficie	encies are cited						
	Survey dates: Ai	agust 10, 11, 2011						
	_	date: August 12, 2011						
	Facility number:	000153						
	Provider number:	: 155249						
	AIM number: 10	0266910						
	C .							
	Survey team:							
	Ann Armey, RN							
	Census bed type:							
	SNF/NF: 140							
	Total: 140							
	Census payor typ	e:						
	Medicare: 7							
	Medicaid: 105							
	Other: 28							
	Total: 140							
	Sample: 6							
LABORATOR	Y DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE			TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VD7W11

Facility ID: 000153

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			E SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL	ETED
		155249	B. WING		<del></del>	08/12/2	011
			1	_	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			6006 BR	RANDY CHASE COVE		
		CARE AND REHAB-FORT WAYNE			/AYNE, IN46815		
(X4) ID		TATEMENT OF DEFICIENCIES	_	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL	l F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
	Supplemental Sa	mple: 3					
		es reflect state findings ace with 410 IAC 16.2.					
F0157 SS=D	A facility must immoresident; consult wand if known, notification representative or a when there is an a resident which respotential for requiring significant change mental, or psychosocial statuconditions or clinical alter treatment significant in a way to adverse consecutive form of treatments.	is in either life threatening cal complications); a need to nificantly (i.e., a need to sting form of treatment due quences, or to commence a nent); or a decision to ge the resident from the					
	The facility must a resident and, if know representative or in when there is a chassignment as spead change in reside	also promptly notify the own, the resident's legal nterested family member range in room or roommate ecified in §483.15(e)(2); or ent rights under Federal or ations as specified in					
	update the addres resident's legal repfamily member.	ecord and periodically as and phone number of the presentative or interested					
		ation, interview and be facility failed to consult	F01	157	F 157 Resident # D was assessed, physician was notified, and o	rders	08/31/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPI	LETED
		155249	A. BUII B. WIN			08/12/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF	PROVIDER OR SUPPLIE	R					
KINDDE	D TDANCITIONAL	CADE AND DELIAD FORT WAYNE	_	1	RANDY CHASE COVE		
KINDKE	D TRANSITIONAL	CARE AND REHAB-FORT WAYNE	=	FORT	WAYNE, IN46815		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
	with the physici	an regarding the need to			received by physician relate	d to	
	continue a treatment that had been discontinued.				wound treatment.		
					All residents' charts were	idonto	
		affected 1 of 3 residents,			reviewed, to ensure that res receiving treatments HAD	idents	
	1	ts were reviewed, in a			accurate, CURRENT physi	cian	
	sample of 6. (Re	•			orderS, WITH necessary	o.a	
	sample of 6. (Re	esident #D)			notification(S) DOCUMENT	ED in	
					the nurses' notes. All notific	ations	
	Finding include:				were made and physicians'		
					orders are in place.		
	The clinical reco	ord of Resident #D was			All licensed nursing staff sha	all be	
	reviewed on 8/1	1/11 at 7:00 a.m., and			in-serviced on policy and procedure regarding Condit	ion	
		sident was admitted to the			Change and timely physicia		
		1, following the surgical			notifications, INCLUDING B		
	repair of a left h				NOT LIMITED TO CONSUL		
	1 ^	•			WITH PHYSICIANS		
	1 *	s, dated 7/19/11, indicated			REGARDING THE NEED T	0	
		(Left) heel c (with) N/S			CONTINUE TREATMENTS		
	(Normal Saline)	then apply Xeroform &			HAVE BEEN DISCONTINU	ED	
	DCD (Dry Clear	n Dressing) bid (twice			PER TIMED ORDER. A	1	
	daily).				performance improvement that has been developed to mon		
	Re-eval (Re-eva	luate) in 14 days then			treatment records, physician		
	rewrite order as	· •			orders, and weekly skin she		
	lewitte order ds	nocucu.			The audits shall be complet		
	The weekly proc	veura ulaar rapart indicated			daily, on scheduled days of	work,	
	1	ssure ulcer report indicated			for 30 days by the DNS, AD		
	1	admitted with a pressure			UM, or designee. Any conce		
		heel and indicated the			will be promptly addressed	with	
	following:				the responsible individuals.  DNS will review findings we	okly	
	On 7/21/11, the	left heel wound was 3 cm			and report to PI committee	CKIY	
	by 4.2 cm, and b	oright pink with a dark			monthly for 6 months to		
	scab in the center. The treatment listed				determine need for CONTIN	IUED	
	was xeroform with dry clean dressing to				monitoring thereafter.		
	area.						
		left wound was described					
	On 8/10/11, the left wound was described						
		irrounding a dark center					
	and indicated the	e treatment continued.	1				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPI	LETED
		155249	B. WIN			08/12/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				RANDY CHASE COVE		
KINDRFI	TRANSITIONAL (	CARE AND REHAB-FORT WAYN	IF		WAYNE, IN46815		
			· <u> </u>				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	BEFREINCT		DATE
	The August 2011	MAR (Medication					
	Administration R	Record) indicated the					
	twice daily treat	ment had automatically					
	stopped on 8/2/1	1 and no other treatment					
	* *	ocumented after that					
	date.						
	auto.						
	On 9/11/11 at 7.7	15 a m the Wound Numa					
		45 a.m., the Wound Nurse					
		The Wound Nurse					
		nt #D still had a dark					
	scab on his left h	eel and she continued to					
	cleanse the woun	nd on the left heel, apply					
	xeroform and a d	lry dressing daily Monday					
	through Friday.						
		e was asked why there					
		the treatment and no					
		ne treatment was done					
		wound nurse stated					
	,	" and indicated she					
		ed the physician and had					
	the treatment reo	ordered."					
	Physician orders	, dated 8/11/11, indicated					
	a new treatment	order was obtained to					
	cleanse the area	on the left heel with					
		d apply xeroform and a					
		g twice daily until					
	healed.	es twice daily diffil					
	nealeu.						
		00 p.m. the area on the					
	left outer heel was observed. The heel was						
	red but blanchab	le with a small pea-sized					
	brown area prese	ent in the center of the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l	00	COMPLETED
	155249	A. BUILDING B. WING		08/12/2011
NAME OF PROVIDER OR SUPPLIED KINDRED TRANSITIONAL (	L CARE AND REHAB-FORT WAYNE	6006 BF	ADDRESS, CITY, STATE, ZIP CODE RANDY CHASE COVE VAYNE, IN46815	
(X4) ID SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	COMPLETION
TAG REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
wound.  3.1-5(a)(3)  The resident has verbal, sexual, pheorporal punishme seclusion.  The facility must resexual, or physical punishment, or in Based on interviting the facility failed free from verbal affected 2 of 3 reallegations of absample of 6.  (Resident #E and Findings included 1. The clinical reviewed on 8/1 indicated the resewhich included 1 mental retardation The MDS (Mini Assessment, data Resident #E had impairment and	the right to be free from ysical, and mental abuse, ent, and involuntary  not use verbal, mental, all abuse, corporal voluntary seclusion.  ews and record review, all to assure residents were abuse. This deficiency esidents, whose use were reviewed, in a all #F)  ecord of Resident #E was 1/11 at 6:00 a.m., and ident had diagnoses out were not limited to, on and depression.	F0223	F 223 1. CNAs #6 & #7 WE SUSPENDED AT THE TIME ALLEGATIONS OF ABUSE WERE MADE AND INVESTIGATIONS WERE CONDUCTED. BASED ON INVESTIGATION FINDINGS BOTH CNA #6 & #7 WERE TERMINATED FROM EMPLOYMENT. 2. INVESTIGATION WAS CONDUCTED, INCLUDING INTERVIEWS OF STAFF AN RESIDENTS. INVESTIGATI FOR RESIDENT #F WAS INITIATED AS A RESULT OF THE INVESTIGATION FOR RESIDENT #E. 3. THE FACILITY WILL ENSURE THALL ALLEGATIONS OF ABUARE INVESTIGATED AND REPORTED TO THE STATE AGENCIES AS REQUIRED. NURSING CENTER STAFF CONTINUE TO RECEIVE EDUCATION RELATIVE TO ABUSE PREVENTION, INVESTIGATION, AND REPORTING WITH INITIAL	ERE 08/13/2011 THE THE S,  ID ION E HAT ISE E WILL

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155249			ULTIPLE CO	NSTRUCTION 00	(X3) DATE S COMPL 08/12/2	ETED	
		155249	B. WIN			06/12/2	011
	PROVIDER OR SUPPLIE		_	6006 BF	ADDRESS, CITY, STATE, ZIP CODE RANDY CHASE COVE		
KINDRE		CARE AND REHAB-FORT WAYN	E .	FORTV	VAYNE, IN46815		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ſΈ	(X5) COMPLETION DATE
	undated, indicate states CNA told Threatened resider crying you are g When resident a meal time, CNA have to go hungi 'If you don't strato eat.'" The alleresident felt the not give her eno The allegation for resident asked to "CNA stated 'i dm Pepsi & (a yourself up." The investigatio #6 was removed suspended on 7/ On 7/17/11 at 3: notes indicated I was talked to inaperson. The note (Resident) recan (Social Worker) reported to E.D. Resident #E was have that caregine eat in her room a	estigation Worksheet, ed on 7/16/11, "resident her she is 'too dm fat.' lent 'if you don't stop this oing to eat in your room.' sked for an alternate at stated 'No, you'll just ry.' CNA also told resident ighten up you're not going gation indicated the CNA was rough and did ugh time to use the toilet. urther indicated when the be pulled up in the chair, f you didn't drink so much and) coke you could move  n report indicated CNA from the building and			EMPLOYEE ORIENTATION PERIODICALLY THEREAFT A PERFORMANCE IMPROVEMENT TOOL HAS BEEN DEVELOPED TO MONITOR COMPLIANCE WABUSE POLICY AND PROCEDURE RELATED TO INVESTIGATION AND REPORTING ALLEGATIONS ABUSE. THE EXECUTIVE DIRECTOR, DIRECTOR OF NURSING SERVICES, ASSISTANT DIRECTOR OF NURSING SERVICES, OR DESIGNEE, WILL COMPLE AUDIT TOOL FOR 30 DAYS EXECUTIVE DIRECTOR OF DIRECTOR OF NURSING SERVICES WILL REVIEW FINDINGS WEEKLY AND REPORT TO PI COMMITTE MONTHLY FOR 6 MONTHS DETERMINE NEED FOR CONTINUED MONITORING THEREAFTER.	TE . 4. R	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155249		(X2) MUI A. BUILI B. WING	DING	nstruction 00	(X3) DATE S COMPL <b>08/12/2</b>	ETED	
NAME OF E	PROVIDER OR SUPPLIER	,	B. WING		DDRESS, CITY, STATE, ZIP CODE		
			_		RANDY CHASE COVE		
		CARE AND REHAB-FORT WAYN			VAYNE, IN46815		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL	l p	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
	A Performance I 7/18/11, indicated discharged for ma resident.  The incident was 7/16/11.  On 8/11/11 at 2: indicated verbal CNA #6 never caresigned.  Review of inserved CNA #6's last ab 6/6/11.  2. The clinical reviewed on 8/11 indicated the resigned facility on 5/8/11 included, but we depressive disord accident.  On 7/1/11 at 3:00 indicated the resigned.	improvement form, dated and CNA #6 was acental and verbal abuse of a reported to the ISDH on abuse was confirmed but ame in for follow-up and are inservice was on a record of Resident #F was 1/11 at 5:25 a.m. and ident was admitted to the lawith diagnoses which are not limited to, der and cerebral vascular abuse of the POA was aware of the			CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
	investigation taking place.						
	-	dent Reporting Form, ed, as part of an abuse					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:			IULTIPLE CO ILDING	NSTRUCTION 00	COMPL	ETED	
		155249	B. WIN			08/12/2	011
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
KINDREI	O TRANSITIONAL C	CARE AND REHAB-FORT WAYN	ΙE		RANDY CHASE COVE VAYNE, IN46815		
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IAG		LSC IDENTIFYING INFORMATION)	-	IAG	DEFECENCE!)		DATE
	•	another resident on t #F "reported to (Staff					
	,	that (CNA #7) refuses to					
	· ·	es 'you need to do things					
	-	esident's name) you have					
		esident reports this was					
		10 days ago, but he did					
	not tell anyone."						
	The report indica						
	_	30/11 and an investigation					
	was conducted.	C					
	The report indica	ated the allegation was					
	substantiated.						
	A performance In	mprovement Form, dated					
	7/11/11, indicated	d the allegation of abuse					
	was substantiated	d and CNA #7 was					
	terminated on 7/1	11/11.					
	Review of inserv	vice records indicated					
	CNA #7's last ab	use inservice was on					
	6/6/11.						
	_	relates to Complaint					
	IN00094324.						
	3.1-27(b)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPL	LETED
		155249	A. BUII			08/12/2	011
			B. WIN		DDDFGG CITY CTATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
KINDDE	O TO A NOITION AL	DADE AND DELIAD FORT WAYNE	_		RANDY CHASE COVE		
KINDREL	) TRANSITIONAL (	CARE AND REHAB-FORT WAYNE		FORT V	VAYNE, IN46815		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0225	,	not employ individuals who					
SS=D		guilty of abusing, neglecting,					
	•	idents by a court of law; or					
		g entered into the State					
		y concerning abuse, neglect,					
		esidents or misappropriation					
		and report any knowledge it					
		a court of law against an would indicate unfitness for					
		e aide or other facility staff to					
		de registry or licensing					
	authorities.	ac region y or meericing					
	The facility must e	ensure that all alleged					
		g mistreatment, neglect, or					
	abuse, including in	njuries of unknown source					
		tion of resident property are					
	•	tely to the administrator of					
		other officials in accordance					
		ough established procedures					
	· <del>-</del>	state survey and certification					
	agency).						
	The feeility may at h						
		nave evidence that all are thoroughly investigated,					
	_	further potential abuse while					
	the investigation is						
	are investigation is	s in progress.					
	The results of all i	nvestigations must be					
		ministrator or his designated					
	-	d to other officials in					
		State law (including to the					
	State survey and	certification agency) within 5					
		ne incident, and if the alleged					
		d appropriate corrective					
	action must be tal		1				
	Based on intervi	ews and record review,	F0	225	F 225		08/31/2011
	the facility failed	d to investigate an					
	_ <del>-</del>	streatment, prevent further			1. AS IS STATED ON PA	.GE	
	_	tment and report the			6 OF THE 2567, "RESIDI		
	•	-				_1 <b>1 1</b>	
	allegation of mis	streatment to the State	1		# B TRANSFERRED TO		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VD7W11 Facility ID: 000153

If continuation sheet

Page 9 of 28

´		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		155249	B. WIN			08/12/20	)11
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
KINDDE	D TDANICITIONIAL C	CADE AND DELIAD FOOT WAYNE	_	1	RANDY CHASE COVE		
		CARE AND REHAB-FORT WAYNE			WAYNE, IN46815		
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PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		ication agency in		IAG	ANOTHER FACILITY O	NI	DAIL
	accordance with	• •			7/29/11", THIS TRANSFI		
		affected 1 of 3 resident,			WAS PER RESIDENT	ZIK	
	1	s of mistreatment were			REQUEST. THUS, NO		
	~				FURTHER ACTION COL	пр	
	reviewed, in a sa	mple of 6.(Resident #B)			BE TAKEN FOR THIS		
	Pinding in 1 4.						
	Findings include				SPECIFIC RESIDENT.		
	00/10/11 -4.0.1	10 · ··· di DON			RESIDENT # B'S		
		10 a.m., the DON			COMPLAINT WAS	ICH	
	`	sing) was interviewed and			INVESTIGATED THROU	JGH	
		ad been an incident			THE FACILITY	DE	
	involving Reside				GRIEVANCE PROCEDU	RE,	
		N indicated LPN #8			DUE TO INITIAL		
		ld her Resident #B was			ALLEGATION BEING		
	_	ecause she felt she had			RELATED TO MEDICAT		
		her breathing treatments			ADMINISTRATION, WI	ГН	
	appropriately.				NO ALLEGATION OF		
	The DON indica				ABUSE STATED. UPON		
	transferred to and	other facility on 7/29/11.			NOTIFICATION OF THE		
					VERBAL ABUSE		
		30 p.m., Resident #B was			ALLEGATION, THE		
		er new facility. The			EXECUTIVE DIRECTOR	≀	
		d she had a conflict with			INITIATED ANOTHER		
	LPN #8 regardin	g her asking aides to go			INVESTIGATION AND		
	to the kitchen too	many times, during			IMPLEMENTED FACILI	TY	
	meals and she fe	lt "disrespected".			ABUSE POLICY. NURSI	Е	
	The resident indi	cated, after this she			WAS SUSPENDED,		
	noticed, when LI	PN #8 gave her breathing			ALLEGATION WAS		
	treatments, her h	eart would pound and she			REPORTED TO THE STA	ATE	
	would have difficulty breathing.				AGENCIES, AND		
	On 7/23/11, she l	had the same reaction			FOLLOWING		
	and the nurse told her she was mixing her				INVESTIGATION; LPN #	# 8	
	respiratory treatments. The resident felt				WAS TERMINATED.		
	the medications	should not have been					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A BUILDING 00			(X3) DATE SURVEY  COMPLETED		
AND PLAN	OF CORRECTION	155249	1	LDING		08/12/2	
		100240	B. WIN		PRESIDENCE CONTROL CON	00/12/2	011
NAME OF	PROVIDER OR SUPPLIE	R		1	ADDRESS, CITY, STATE, ZIP CODE		
KINDRE	D TRANSITIONAL	CARE AND REHAB-FORT WAYNI	Ē	1	VAYNE, IN46815		
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PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	<b>†</b>	R LSC IDENTIFYING INFORMATION)	<del> </del>	TAG	DEFICIENCY)		DATE
		vas causing her to have			2. ALL RESIDENTS WE		
		felt she should have been			INTERVIEWED TO ENS		
	_	tal. She spoke to the			NO OTHER ALLEGATIC	NS	
	_	fter that, LPN #8 never			OF ABUSE WERE		
	1 -	tions again but she kept			UNREPORTED. NO OTH	IER	
	coming by her re	_			RESIDENTS MADE		
		e talked to the social			ALLEGATIONS OF ABU		
		her life was in danger and			ALL STAFF GRIEVANCE		
		the facility. The resident			RESIDENT GRIEVANCE	-	
	1	e day she left, LPN #8			FAMILY GRIEVANCES,		
	came into her ro	om to check her			WELL AS EVENT REPO		
	roommate's bloc	od sugar and "my heart			FROM THE LAST 60 DA	YS	
	stopped" becaus	e "I was so scared" of her.			WERE REVIEWED FOR		
					POTENTIAL ABUSE		
	On 8/10/11 at 2:	00 p.m., the DON	ALLEGATIONS REQUIRING				
	1	nacy report, dated			ABUSE POLICY		
	8/10/11, indicati	ng giving the two			IMPLEMENTATION. NO	NE	
	respiratory medi	cations together was not	WERE IDENTIFIED.				
	contraindicated	and a written statement					
	from the residen	t's physician, dated			3. THE FACILITY WILL		
		ng the two respiratory			ENSURE THAT ALL		
	treatments "may	cause increased			ALLEGATIONS OF ABU	SE	
	sympathetic acti	vity when administered			ARE REPORTED TO TH	Е	
	together but wou	ıld not cause actual harm			STATE AGENCIES AS		
	to the resident."				REQUIRED. ALL STAFF		
					WILL BE IN-SERVICED	ON	
	On 8/10/11 at 3:	05 p.m. LPN #8 was			ABUSE PREVENTION		
	interviewed and	she indicated she mixed			POLICY AND PROCEDU	JRE,	
	two breathing m	edications together and			INCLUDING BUT NOT		
	Resident #B complained of feeling sick				LIMITED TO DEFINITION	ONS	
	after the treatments. LPN #8 indicated she				OF ABUSE, AND		
	took the resident	ts vital signs and they	INVESTIGATIVE				
	were fine. She c	alled the physician, the			/REPORTING PROTOCO	LS.	
	pharmacy, the S	upervisor and the Director			A PERFORMANCE		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155249		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE : COMPL 08/12/2	ETED		
KINDREI		CARE AND REHAB-FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN46815					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ſΕ	(X5) COMPLETION DATE	
TAG	of Nursing to infisituation. The number resident if she hospital but she of She wrote do not the resident had a medications were indicated, after 7 Resident #B's medicated after 7 Resident #B's medicated the resident indicated the resident indicated the resident facility on 7/12/1 included and were obstructive pulmore respiratory failure pneumonia.  The MDS (Mining Assessment, date resident had no continuous indicated the resisting indicated the resisting included; blood prate of 89, respiratory failure of 89, respiratory failur	form them of the rse indicated she asked e wanted to go to the declined.  I mix on the MAR since a reaction when the e mixed. The nurse /23/11, she never gave edications.  By p.m., the clinical and the same and th		TAG	IMPROVEMENT TOOL I BEEN DEVELOPED TO MONITOR COMPLIANC WITH ABUSE POLICY A PROCEDURE RELATED INVESTIGATION AND REPORTING ALLEGATI OF ABUSE. THE EXECUTIVE DIRECTOR DIRECTOR OF NURSING SERVICES, ASSISTANT DIRECTOR OF NURSING SERVICES, OR DESIGNI WILL COMPLETE AUDI TOOL FOR 30 DAYS.  4. EXECUTIVE DIRECT OR DIRECTOR OF NURSING SERVICES WIRE REVIEW FINDINGS WEEKLY AND REPORT PI COMMITTEE MONTH FOR 6 MONTHS TO DETERMINE NEED FOR CONTINUED MONITOR THEREAFTER.	HAS  EE AND TO ONS  G G EEE, T  TO TOR HLL TO HLY	DATE	
	did not want to g	indicated the resident o to the hospital.						

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155249	B. WIN			08/12/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	8			RANDY CHASE COVE		
KINDREI	D TRANSITIONAL (	CARE AND REHAB-FORT WAYN	Ξ	1	WAYNE, IN46815		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
IAG	A grievance form indicated Reside "nasty c (with) my breathing tx am having side e shows no remore (treatment). She bothering me. I compare the resolution where would provide the social service of the room and experimental transfer to another began to cry upon her nurse 'tried to mixing three treates (sic) trying to in here walking a gonna do?'you don't know I'm be	n, dated 7/26/11, nt #B stated LPN #8 is ne at mealtimeshe mixes ( treatment) together and I effects(LPN's Name)		IAG			BAIL
	A Resident Trans	sfer Form indicated the asferred to another facility					

000153

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	155249	A. BUI	LDING	00	COMPL 08/12/2	
		133249	B. WIN			00/12/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CODE		
KINDREI	D TRANSITIONAL C	CARE AND REHAB-FORT WAYN	JE		RANDY CHASE COVE VAYNE, IN46815		
			<u> </u>	<u> </u>	WATER HATOUTO		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· `	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
-	after the allegation			_			
		ii was maac.					
	On 8/11/11 at 10	:00 a.m., the Scheduler					
		dicating LPN #8 worked					
	on Resident #B's	•					
		7/27/11 and 7/29/11.					
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,_,,=,, <del>,,=,</del> ,,_,,=,,					
	On 8/11/11 at 11:	:00 a.m., the					
		as interviewed. The					
	Administrator in	dicated the incident was					
		ut the focus was on the					
	1 -	She indicated, on					
	8/10/11, when sh	,					
	· ·	rom 7/26/11 and 7/28/11,					
		the resident was fearful					
		was trying to kill her,					
		initiated an investigation,					
	1	rse, and reported the					
	allegation to the						
	The abuse policies	es, "Responding to and					
	Investigating an	Abuse Allegation, dated					
	7/22/10 and "Cor	nducting an					
		ated 6/30/06, provided by					
	the Administrator	r and Corporate Nurse,					
		re reviewed on 8/11/11 at					
	4:00 p.m. and inc	licated					
		cutive Director and					
	Director of Nursi	ing ImmediatelyBegin					
	an internal invest	tigationReport the					
	alleged abuse to	the appropriate state					
	agencies in accor	dance with state					
	lawprotect the	resident(s) and to					
	prevent a possibl	e reoccurrence during the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE S COMPL			
AND FLAN	155249		A. BUII		00	08/12/2		
			B. WIN		DDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER				RANDY CHASE COVE			
KINDREI	O TRANSITIONAL C	CARE AND REHAB-FORT WAYNE						
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Œ	COMPLETION DATE	
F0226 SS=D	investigation (i.e. from any resident the accused emplication)"  This Federal tag in IN00094324.  3.1-28(c) 3.1-28(d)  The facility must downitten policies and mistreatment, negliand misappropriate Based on interreview, the fact their policy for reporting, and following an a abuse/mistreatment this deficiency residents, who mistreatment with sample of 6. (Findings including inclu	evelop and implement d procedures that prohibit lect, and abuse of residents ion of resident property. views and record cility failed to follow r investigating, protecting a resident llegation of ment. y affected 1 of 3 se allegations of vere reviewed, in a Resident #B)	F0	226	F 226  1. ALTHOUGH RESIDEND NO LONGER RESIDESTHE FACILITY, THE ABENDATION WAS IMPLEMENTED UPON EXECUTIVE DIRECTOR BEING NOTIFIED OF THE ALLEGATION. THE FACILITY HAD ADDRESSED A PREVIOUS CONCERN RELATED TO MEDICATION ADMINISTRATION BY IF # 8, AS INITIALLY	S AT EUSE R HE US	08/31/2011	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VD7W11 Facility ID:

000153

If continuation sheet

Page 15 of 28

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00			(X3) DATE SURVEY  COMPLETED  08/12/2011			
		155249	B. WIN			08/12/201	1	
	PROVIDER OR SUPPLIER D TRANSITIONAL (	CARE AND REHAB-FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE  6006 BRANDY CHASE COVE  FORT WAYNE, IN46815					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	$\overline{}$	ID	PROVINCE NO AND CORPORATION		(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	<sub>TE</sub> (	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE	
	(Director of N	ursing) was			REPORTED, THROUGH			
	interviewed ar	nd indicated there had			THE GRIEVANCE			
	been an incide	nt involving Resident			PROCEDURE. STAFF			
	#B and	$\mathcal{E}$			MEMBERS INVOLVED			
		OON indicated LPN			WITH RESIDENT # B'S			
		and told her Resident			ALLEGATION HAVE BE	EEN		
					COUNSELED AND	. то		
	_	with her because she			IN-SERVICED RELATEI	) 10		
		t administered her			ABUSE REPORTING			
	breathing treat	ments appropriately.			PROCEDURES.			
	The DON indi	cated Resident #B			2. ALL RESIDENTS WE	DE		
	transferred to	another facility on			INTERVIEWED TO ENS	I .		
	7/29/11.	•			NO OTHER ALLEGATION	I .		
	,,_,,,,,,				OF ABUSE WERE			
	On 9/10/11 at	1:20 n m Pagidant			UNREPORTED. NO			
		1:30 p.m., Resident			FURTHER ALLEGATION			
		ewed at her new			OF ABUSE WERE			
	-	esident indicated she			COMMUNICATED DUR	ING		
	had a conflict				THIS AUDIT. ALL STAI	FF		
	regarding her	asking aides to go to			GRIEVANCES, RESIDEN	T		
	the kitchen too	many times, during			GRIEVANCES, FAMILY			
	meals and she	felt "disrespected".			GRIEVANCES, AS WEL	LAS		
		ndicated, after this			EVENT REPORTS FROM	1		
		hen LPN #8 gave her			THE LAST 60 DAYS WE	RE		
	· ·	ments, her heart			REVIEWED FOR			
	_				POTENTIAL ABUSE			
	_	and she would have			ALLEGATIONS REQUIF	RING		
	difficulty brea	•			ABUSE POLICY			
	On 7/23/11, she had the same reaction and the nurse told her she				IMPLEMENTATION. NO	NE		
					WERE IDENTIFIED.			
	was mixing he	r respiratory			2 THE DAOUTENAME.			
	treatments. Th	e resident felt the			3. THE FACILITY WILL	·		
					ENSURE THAT ABUSE			

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ĺ	LDING	NSTRUCTION 00	COMPLE		
		155249	B. WIN			08/12/20	11	
NAME OF I	DROVIDED OD CUDDI IEI	<u> </u>			DDRESS, CITY, STATE, ZIP CODE			
	PROVIDER OR SUPPLIE		6006 BRANDY CHASE COVE					
KINDRE	D TRANSITIONAL	CARE AND REHAB-FORT WAYN	E	FORT W	VAYNE, IN46815			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	1	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	JE	COMPLETION DATE	
1710		hould not have been		mo	POLICY IS IMPLEMENT	-	DATE	
	l	s was causing her to			TO THE FULL EXTENT			
		cts. She felt she			INTENT TO PROHIBIT			
	l				MISTREATMENT,			
	l	een sent to the			NEGLECT AND ABUSE	OF		
	hospital. She				RESIDENTS AND			
	1 -	d after that, LPN #8			MISAPPROPRIATION O			
	1	r medications again			RESIDENT PROPERTY.	ALL		
	but she kept c	oming by her room,			STAFF WILL BE			
	smiling.				IN-SERVICED ON ABUS POLICY AND PROCEDU	I .		
	She indicated	she talked to the			INCLUDING BUT NOT	JKE		
	social worker	and told her life was			LIMITED TO			
	in danger and	she had to leave the			INVESTIGATING,			
	facility. The r	esident indicated, on			REPORTING, AND			
	the day she le	ft, LPN #8 came into			PROTECTING RESIDEN	TI T		
	1	heck her roommate's			FOLLOWING AN			
	l	nd "my heart stopped"			ALLEGATION OF			
	_	s so scared" of her.			ABUSE/MISTREATMEN	IT. A		
	occurse 1 wa	S SO SCAPCE OF HOT,			PERFORMANCE			
	On 8/10/11 at	2:00 p.m., the DON			IMPROVEMENT TOOL BEEN DEVELOPED TO	HAS		
		armacy report, dated			MONITOR COMPLIANO	re		
	^				WITH ABUSE POLICY A			
		ating giving the two			PROCEDURE. THE			
	1 1	edications together			EXECUTIVE DIRECTOR	₹,		
		aindicated and a			DIRECTOR OF NURSIN	G		
	written statem				SERVICES, ASSISTANT			
	1 ^ *	sician, dated 8/10/11,			DIRECTOR OF NURSIN	G,		
	indicating the two respiratory treatments "may cause increased				OR DESIGNEE, WILL			
					COMPLETE AUDIT TOO	)L		
	sympathetic activity when				FOR 30 DAYS.			
	administered	together but would			4. EXECUTIVE DIRECT	TOR		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SU: COMPLET		
ANDILAN	or connection	155249	1	LDING	00	08/12/201	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER		6006 BRANDY CHASE COVE				
KINDREI	D TRANSITIONAL C	CARE AND REHAB-FORT WAYNE	Ξ	FORT V	VAYNE, IN46815		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE (	COMPLETION DATE
	not cause actual harm to the				OR DIRECTOR OF		
	resident."				NURSING SERVICES W	ILL	
					REVIEW FINDINGS		
	On 8/10/11 at	3:05 p.m. LPN #8			WEEKLY AND REPORT PI COMMITTEE MONTI		
	was interviewe	ed and she indicated			FOR 6 MONTHS TO	ILI	
	she mixed two	breathing			DETERMINE NEED FOR	١	
	medications to	gether and Resident			CONTINUED MONITOR	ING	
	#B complained	d of feeling sick after			THEREAFTER.		
	the treatments.	. LPN #8 indicated					
	she took the re	esidents vital signs					
	and they were	fine. She called the					
	physician, the	pharmacy, the					
	_	d the Director of					
		orm them of the					
		nurse indicated she					
		lent if she wanted to					
		ital but she declined.					
		not mix on the MAR					
		ent had a reaction					
		ications were mixed.					
		cated, after 7/23/11,					
	_	e Resident #B's					
	medications.						
	On 8/10/11 of	3:30 n m the clinical					
	On 8/10/11 at 3:30 p.m., the clinical record of Resident #B was reviewed and indicated the resident						
		to the facility on					
		liagnosis which					
	,,,12,11 With a						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMPI			
		155249	A. BUI B. WII	ILDING NG		08/12/2		
			В. W II		DDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIER	R.	6006 BRANDY CHASE COVE					
KINDREI	O TRANSITIONAL (	CARE AND REHAB-FORT WAYN	IE .	FORT V	VAYNE, IN46815			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI	2	(X5)	
PREFIX TAG	•	ICY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE	
		were not limited to,						
		ctive pulmonary						
		ic respiratory failure,						
	asthma and pn	1 ,						
	astillia alla pi	e difficilia.						
	The MDS (Mi	nimum Data Set)						
	Assessment, d							
	,	resident had no						
	cognitive impa							
	Nursing notes	, dated 7/23/11 at						
		icated the resident						
	•	sickness and chest						
	_	indicated the vital						
	*	en and included;						
		e of 124/73, heart rate						
	_	ion of 18, temperature						
	_	n O2 saturation of						
	98%.	ii O2 Sataration of						
		eated the Physician,						
		arsing and Supervisor						
		The nursing note						
		resident did not want						
	to go to the ho							
	13 50 10 110	~F						
	A grievance fo	orm, dated 7/26/11,						
	_	dent #B stated LPN						
	#8 is "nasty c							
	*	e mixes my breathing						
		in the state of th						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155249		A. BUI	LDING	00	COMPL 08/12/2		
		133249	B. WIN		DDDDGG GITTY GTATE ZID GODE	00/12/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE RANDY CHASE COVE		
KINDREI	O TRANSITIONAL C	CARE AND REHAB-FORT WAYN	E	1	VAYNE, IN46815		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	` ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION DATE
1710		together and I am		mo	·		DATE
	` ′	fects(LPN's Name)					
	_	orse for mixing tx.					
		ne still coming in					
	,	g me. I don't want her					
	· ·	resolution was that					
		ould provide the					
	resident's med	_					
	resident's med	ication.					
	A social servic	ee note, dated 7/28/11					
		indicated she was					
	· ·	"res (resident) is very					
		n her room and					
		esire to transfer to					
	•	yres (resident)					
		pon writer's entry,					
		rse 'tried to kill me					
		nixing three treatment					
	_	he be (sic) trying to					
	_	e's just up in here					
		3 1					
	_	d all day. What you					
	_	ou know! don't act					
	*	know I'm being					
	_	nst for making a					
	complaint to the	he DON on her"					
	A Resident Tre	ansfer Form indicated					
		as transferred to					
		y on 7/29/11 at 6:30					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155249		A. BUI	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  08/12/2011	
	PROVIDER OR SUPPLIER	L CARE AND REHAB-FORT WAY	<u> </u>	STREET A	DDRESS, CITY, STATE RANDY CHASE C /AYNE, IN46815			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE A	TO THE APPROPRIATE	(X5) COMPLET DATE	ΓΙΟΝ
	p.m.							
	allegations of investigated, ror that protect the resident af made.  On 8/11/11 at Scheduler protect. LPN #8 worker hall on 7/23/17/27/11 and 7/27/11 at Administrator Administrator	11:00 a.m., the was interviewed. The						
	She indicated, reviewed the 6 7/26/11 and 7/ indicated the r	esident was fearful						
	her, she immedinvestigation,	rse was trying to kill diately initiated an suspended the nurse, ne allegation to the	VD7W11	Facility II	D: 000153	If continuation shee	et Page 21 of 2	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
AND PLAIN	OF CORRECTION	155249	1	LDING	00	08/12/2	
		100210	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/12/2	
NAME OF F	PROVIDER OR SUPPLIER				RANDY CHASE COVE		
KINDREI	O TRANSITIONAL C	CARE AND REHAB-FORT WAYN	E	1	VAYNE, IN46815		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	IAG	DLI ICILITO I )		DATE
	The abuse poli	icies, "Responding to					
	and Investigati						
	_	ted 7/22/10 and					
	_	n Investigation",					
	_	provided by the					
		and Corporate Nurse,					
		vere reviewed on					
		p.m. and indicated					
		Executive Director					
	and Director o						
		Begin an internal					
	-	Report the alleged					
	-	opropriate state					
	_	cordance with state					
	_	he resident(s) and to					
	_	ible reoccurrence					
	_	estigation (i.e.,					
	_	emoved from any					
	_	•					
		et, Suspension of the					
	accused emplo						
	investigation).						
	This Federal ta	ag relates to					
		~					
	Complaint IN(	JUU74344.					
	3.1-28(a)						
	3.1-20(a)						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII		NSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155249	B. WIN			08/12/2	011
	PROVIDER OR SUPPLIER  O TRANSITIONAL C	CARE AND REHAB-FORT WAYNE	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE RANDY CHASE COVE VAYNE, IN46815		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	ID		PROVIDENCE N. AV OF CONNECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
F0323 SS=J	environment remainazards as is possible receives adequated devices to prevent Based on interviet the facility failed impaired resident unattended and facility found outside of This resulted in the facility unattended (Resident #C)  The immediate jewhen Resident #C  The immediate jewhen Resident #C  Director of Nursiwere notified of toon 8/11/11 at 3:33. The immediate jewhen Resident #C  B/11/11, but none the lower scope a actual harm with minimal harm the Jeopardy.  Findings include:	to prevent a cognitively the facility then he was initially the facility. The potential for serious esident, who left the ed, in a sample of 6.  The copardy began on 7/5/11, Country left the facility executive Director, and and Corporate Nurse the immediate jeopardy to p.m. the copardy was removed on compliance remained at and severity level of no potential for more than that is not Immediate	F0	323	F 323 The facility requests the this plan of correction be considered its credible allegated of compliance. Submission of response and Plan of Corrections not a legal admission that deficiency exists or that this statement of deficiency was correctly cited and is also not be construed as an admission interest against the facility, the Administrator, or any employ agents, or other individuals with draft or may be discussed in response and Plan of Correction and submission of the Plan of Correction does not constitute admission or agreement of a kind by the facility of the truth any facts alleged or the corrections of a conclusions forth in this allegation by the survey agency. Accordingly, facility has prepared and submitted this Plan of Corrections of a conclusions forth in the submission of the Plan of Corrections and submitted this Plan of Corrections of the Plan of Corrections a condition to participate in the Title 18 and 19 programs. The submission of the Plan of Corrections a condition to participate in the Title 18 and 19 programs. The submission of the Plan of Corrections a condition within	ation of this tion a  t to n of ne ee, //ho the tion.  e an ny n of set the ction eal of the d	08/13/2011

<b>i</b>		(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE S			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE		
		155249	B. WIN			08/12/20	711	
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE			
KINDDE	O TOANGITIONAL C	CARE AND REHAB-FORT WAYN	_		RANDY CHASE COVE			
		-		FORT	WAYNE, IN46815			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
IAG		dent was readmitted	+	IAG	timeframe should in no way	he	DAIL	
					construed as admission of g			
	•	on 6/30/11, with			of non-compliance by the fac	cility.		
	-	included, but were not			Corrective action taken			
	-	ntia and end stage renal			resident found to have bee affected by the deficient	n		
	disease with hem	iodialysis.			practice: Resident # C was			
	The MDC (M	Data Cat)			returned to the nursing center			
	The MDS (Minir	· · · · · · · · · · · · · · · · · · ·			6:10 p.m. on 7/5/11. Reside			
	,	ted 4/26/11 and 7/7/11,			was assessed for injury upon			
		t #C had scores of 10 and			return to facility, 7/5/11, with noted. A new Wander/Elope			
		on the BIMS (Brief			Risk Evaluation was comple			
		ntal Status) indicating the			on 7/5/11 for resident. Resident.	dent		
	resident had mod	lerate cognitive			was immediately placed on	1:1		
	impairments.				staff monitoring at 6:10 pm, 7/5/11, and showed no addit	ional		
					exit seeking behavior. Residual			
	_	pement Risk Evaluations,		physician and family were notified of the event on 7/5/11. An				
		d 6/30/11, indicated						
	Resident #C was	not an elopement risk.			investigation was immediate	ly		
					initiated, 7/5/11. Given that resident stated that he "want	ted a		
		30 a.m., nursing notes			pizza", pizza delivery numbe			
		nt #C went out the back			posted and was provided to			
	therapy door with	h a vendor.			resident on 7/6/11. CNA			
					assignment sheet was upda on 7/6/11. Resident's Behav			
		30 p.m., CNA #1 was			Assessment was updated or			
		rding the incident. CNA			7/6/11. Careplan was updat			
	·	7/4/11, she was sitting at			reflect current interventions.			
	_	ch at the back of the			Nutrition Services Manager (NSM) reviewed dialysis			
	-	Resident #C standing			nutritional provisions on 7/6/	11		
		py door by the back			with no concerns identified.			
		approached the resident			updated food preferences or			
		m back into the building.			7/6/11. Resident was transfe	erred		
	The CNA indicat	ted Therapist #2 came to			to the secured Reflections  Dementia Unit on 7/9/11 at v	vhich		
	meet them just as	s they entered the			time the 1:1 monitoring was			
	building.				discontinued. II. Corrective	•		
	On 8/11/11 at 1:3	35 p.m., Therapist #2 was			action taken for those			

STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING  B. WING		00	COMPLETED	
155249		155249				08/12/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	₹			RANDY CHASE COVE		
KINDRED TRANSITIONAL CARE AND REHAB-FORT WAYNE							
				L	, , , , , , , , , , , , , , , , , , , ,		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		+	TAG	<u> </u>	4:-1	DATE
	1	arding the incident. She		residents having the po to be affected by the sa		liai	
		ent #C walked out of the			deficient practice: A facility wide audit was conducted on 7/5/11 at		
	facility with a ve	endor and the vendor went					
	back into the fac	ility and told her a			the time of the elopement to		
	resident had gon	e out of the door.			ensure all residents were present		
					and accounted for, all reside	nts	
	On 7/5/11 at 5:45 p.m., nursing notes indicated the resident was seen in the assisted dining room.  On 7/5/11 at 6:00 p.m., nursing notes indicated Resident #C was seen by an employee outside of the facility by the bus stop.  A statement from Speech Therapist #5, who is no longer employed by the facility, dated 7/5/11, indicated:  "When I was leaving from work at 5:40				were accounted for. All exit	l l	
					were checked by the Maintenance Director on 7/5/11 with all found to be in working		
					order. Door code was chang	-	
					on 7/5/11. New	jou	
					Wander/Elopement Risk		
				Evaluations were completed for			
					all residents and verified by t	:he	
					IDT on 7/6/11 to ensure all		
					residents at risk for elopeme		
					were identified. CNA assign sheets were updated on 7/6/		
				and careplans were reviewed and updated, as necessary, to reflect			
		•			current status. Elopement		
		saw (Resident #C's name)			Binders were reviewed and		
	1 * '	armacy) walking toward			updated on 7/6/11 to include		
	Maplecrest Road; so I returned back to the facility & (and) checked with therapy				residents currently at risk for		
					elopement. Door Security Vocanducted Preventive	endor	
	whether he is all	owed to be out of the			Maintenance check on all do	ore &	
	facility for which	h they said; they did not			system and verified all to be		
	know: then I we	nt to (MDS Co-ordinators			working order on 7/6/11. An		
		about what happened &			was conducted on 7/6/11 of	the	
		immediately to look for			Preventive Maintenance tool		
	1 ' '	a picture of (Resident			entitled "Door Security Syste		
					for the time period of Januar		
		and) was asked to check			2011 through June 2011 with 100% compliance noted, and		
	for him in (Name of Pharmacy): I parked				concerns noted. Signs were	1110	
	1 -	narmacy) parking lot &			posted at all exit doors on 8/	11/11	
	(and) was about to go in (the Pharmacy) to check; when I saw (resident's name)				directing visitors to ensure th		
					resident exits the facility as t		
	walking out of the	ne pizza shop; I crossed			exit. Letters are being sent o	n	

000153

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155249 08/12/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6006 BRANDY CHASE COVE KINDRED TRANSITIONAL CARE AND REHAB-FORT WAYNE FORT WAYNE, IN46815 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE the road & (and) helped him cross the 8/12/11 to family members/responsible parties and road, got him in my car & (and) got him to vendors reminding them to be back into the nursing home/facility." mindful of ensuring that no resident exits the facility when A statement by the DON (Director of they are entering or exiting. III. The measures put into place Nursing) indicated Resident #C was and systemic change made to returned to the facility at 6:00 p.m., and ensure the deficient practice when he was questioned, indicated he does not recur is: Nursing went out the side door. center staff have received re-education relative to facility policy for Resident Elopement. On 7/5/11 at 6:10 p.m., nursing notes including but not limited to indicated Resident #C was escorted back ensuring residents are maintained into the building and "..when asked how in a safe situation and the need for immediate initiation of he got out res (resident) said he waited @ thorough investigation. Education (at) the door til it opened..." The note also included "CODE PURPLE" to indicated the resident was assessed and be utilized in the event a resident placed on one to one supervision. is suspected to be missing beginning on 7/5/11 and continuing through 7/7/11. Any Subsequent nursing notes and monitoring employee who was unable to sheets indicated Resident #C remained on attend, due to PRN status or one to one supervision through 7/9/11, other reason, has been sent a certified letter. Said employees when he was transferred to the secured are not permitted to return to unit. work until in-service education has been completed. Elopement The incident was reported to the ISDH on Drills were conducted daily 7/6/11 and the follow up report indicated beginning 7/6/2011 through 7/11/11 with good response times the following preventive measures were noted during the drills. taken: Thereafter, Elopement Drills were \*Resident C's elopement risk evaluation scheduled to be conducted ongoing on a monthly basis. The was updated; schedule for Elopement Drills has \*Pizza delivery numbers were posted and been revised, these drills will be provided to the resident along with conducted daily for 2 weeks, encouragement to request assistance from beginning on 8/11/11 through 8/25/11. Thereafter, Elopement

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VD7W11

000153

Facility ID:

If continuation sheet

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUI	ILDING	00	08/12/2		
		133249	B. WIN			00/12/2		
NAME OF PROVIDER OR SUPPLIER				1	ADDRESS, CITY, STATE, ZIP CODE			
KINDRED TRANSITIONAL CARE AND REHAB-FORT WAYNI			IE	1	RANDY CHASE COVE VAYNE, IN46815			
			·	<u> </u>	VATNE, IN40015			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION DATE	
IAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		-	IAG	Drills will be conducted week	dy for	DATE	
	*The door code was changed by the Maintenance Director, on 7/5/11;  *All door alarms were inspected and were in working order;  *A door inspection was completed by the door security vendor and the report indicated the elopement was not a result of system failure;  *Resident #C's nutritional status was re-assessed to verify needs were being met;  *Resident #C's care plan and CNA assignment sheet were updated;  *Resident was transferred to the secure unit, on 7/9/11;  *All facility residents' elopement risk evaluations, care plans and assignments				30 days, through 9/23/11. A			
				concerns identified during thes				
					drills will promptly be addres			
					with the responsible individua			
					Findings will be provided to t			
					Executive Director for review monthly Performance	at		
					Improvement meetings.			
					Maintenance Supervisor			
				completed Preventive				
					Maintenance Tool, "Door Sed			
					Systems" daily for the period			
					7/5/2011 through 7/11/11, an then weekly for 30 days with			
				100% compliance noted, and no concerns identified. This PM schedule has been revised, the "Door Security Systems" check will be completed daily for 2 weeks, beginning on 8/11/11 through 8/25/11. Thereafter, the				
	were updated;	1 1.4.1.			"Door Security Systems" will			
	*Elopement binders were updated;			conducted weekly for 30 days,				
		lopement policy and the			through 9/23/11. Any identifi			
	elopement binders was provided to all staff including therapy, housekeeping and				concerns/issues will be prom addressed and corrected.	ptly		
					Findings will be provided to t	he		
	laundry staff;				Executive Director for review			
	1 ^	ls were conducted each			monthly Performance			
	day from 7/6/11	through 7/11/11 and will			1	′. <b>To</b>		
	be done monthly for 90 days.				ensure the deficient practic			
	*Door security a	audits were reviewed			does not recur, the monitor system established is: The	_		
	between 1/11 th	rough 6/11 with 100			Maintenance Supervisor, or	,		
	percent complia	nce.			designee, shall report to PI			
	*Door security audits were done and reviewed each day between 7/5/11 and				monthly all tracking, trending	and		
					data analysis related to			
	7/11/11.	, <del></del>			Elopement Drills and Door			
	.,				Security Systems checks for further recommendations, ne			
	The immediate i	eopardy that began on			for continued monitoring, and			
	1 - 110 mmmeanate j	Topara, mat objain on			<b>J</b> ,			

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 08/12/2011		
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
IAU	7/5/11 was remo facility develope provide inservice drills, security at letters to families signs at the doors develop care plan elopement and dwith information and residents.  Although the impremoved, the non the lower scope a actual harm with minimal harm the Jeopardy for residence.	ved on 8/11/11, when the d a systematic plan to e training, elopement dits, and safety reminder s/vendors, post safety s, assess all residents, ns for residents at risk of evelop elopement binders regarding procedures  mediate jeopardy was acompliance remained at and severity level of no potential for more than at is not Immediate dents at risk for se of the need for	IAG	resolution. V. Completion II 8.12.11			